

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) HCP   ( ) IE   ( ) IC	<b>Response Timely Filed?</b> ( x) Yes   ( ) No
Requestor's Name and Address Northeast Methodist Hospital C/o Thompson, Coe, Cousins & Irons, LLP 701 Brazos, Suite 1500 Austin, TX 78701	MDR Tracking No.:                      M4-03-8495-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address University Health System/Rep. Box #: C/o Hammerman & Gainer, Inc P.O. Box 1090 Austin, TX 78767	Date of Injury:
	Employer's Name:                      University Health System
	Insurance Carrier's No.:              WC9714531317

## PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
1-9-03	1-14-03	Inpatient Hospitalization	\$21,415.48	\$00.00

## PART III: REQUESTOR'S POSITION SUMMARY

Position summary was not submitted. However, the Respondent's rationale on the Table of Disputed Services states, "Claim should be paid at 75% as bill exceeds 40K".

## PART IV: RESPONDENT'S POSITION SUMMARY

Respondent's rationale on the Table of Disputed Services states, "F – Fee guideline MAR Reduction Stop loss method".

## PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed \$40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the documentation provided by both parties, it **does** appear that this particular admission involved "unusually extensive services." In particular, this admission resulted in a hospital stay of 5 days based upon "1. L2 laminectomy. 2. L3 laminectomy. 3. L1 partial laminotomy. 4. L2-3 discectomy. 5. Interbody cage insertion L2-3. 6. Interbody cage insertion L3-4. 7. Posterior fusion L2-3. 8. Posterior fusion L3-4. 9. L4-5 exploration of spinal fusion. 10. L4-5 removal of prior posterior segmental instrumentation. 11. L4-5 posterior segmental instrumentation. 12. L3-4 posterior segmental instrumentation. 13. L2-3 posterior segmental instrumentation. 14. Extraction of prior EBI insertion. 15. Insertion of new electrical bone stimulator. 16. Intraoperative diskogram L3-4. 17. Intraoperative diskogram L2-3. 18. Dural repair. Accordingly, the stop-loss method does apply and the reimbursement is to be based on the stop-loss methodology.

In determining the total audited charges, it must be noted that the insurance carrier has indicated some question regarding the charges for the implantables. The requestor billed \$67,599.00 for the implantables. The carrier paid \$24,608.10 for the implantables. The key issue is what amount would represent the usual and customary charges for these implantables in determining the total audited charges. The requestor provided the Commission with documentation on the actual cost of implantables, \$13,199.00.

Based on a review of numerous medical disputes and our experience, the average markup for implantables in many hospitals is 200%. This amount multiplied by the average mark-up of 200% results in an audited charge for implantables equal to \$26,398.00.

The audited charges for this admission, excluding implantables, equals \$25,907.30. This amount plus the above calculated audited charges for the implantables equals \$52,305.30, the total audited charges. This amount multiplied by the stop-loss reimbursement factor (75%) results in a workers' compensation reimbursement amount equal to \$39,228.98. The Respondent reimbursed the Requestor \$44,038.57.

Considering the reimbursement amount calculated in accordance with the provisions of rule 134.401(c) compared with the amount previously paid by the insurance carrier, we find that no additional reimbursement is due for these services.

#### PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Findings and Decision by:

Roy Lewis

6-17-05

Authorized Signature

Typed Name

Date of Order

#### PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on \_\_\_\_\_. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

#### PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_